Section 104. NEW PROVIDERS, CHANGE OF OWNERSHIP:

(a) CHANGE OF OWNERSHIP.

If a hospital undergoes a change of ownership, the new owner shall continue to be reimbursed at the prospective rate in effect. The new owner may appeal its rate subject to the provisions of Section 113. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs in the fiscal year for which the cost report is submitted, the department shall use a partial fiscal year cost report to arrive at a prospective rate. This cost will be annualized and indexed appropriately.

(b) NEWLY CONSTRUCTED OR NEWLY PARTICIPATING HOSPITALS

Until a fiscal year end cost report is available, newly constructed or newly participating hospitals shall submit an operating budget and projected number of patient days within thirty (30) days of receiving Medicaid certification. A prospective rate shall be set based on this data, not to exceed the upper limit for the class. This prospective rate shall be tentative and subject to settlement at the time the first audited fiscal year end report is received from the Medicare intermediary. During the projected rate year, the budget can be adjusted if indicated, and justified

by the submittal of additional information.

(c) MERGED FACILITIES

In the case of two (2) separate entities that merge into one (1) organization, the Department for Medicaid Services shall merge the latest available data used for rate setting. Bed utilization statistics shall be combined, creating new occupancy ratios. Costs shall also be combined using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs. The rate of increase control (RIC) applicable to each entity shall be computed on a weighted average, based on the reported paid Medicaid days for each entity taken from the cost report previously used for rate setting. If one (1) of the entities merging has disproportionate status and the other does not, the merged entity shall retain the status of the entity which reported the highest number of Medicaid days paid. These merged per diem rates shall be subject to an appeals process. Finally, each provider shall submit a "Close of Business" Medicaid cost report for the period ended as of the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on

the day before the merger. This report shall be due from the provider within the time frame outlined in Section 109 of this manual. Medicaid cost reports for the period starting with the day of the merger and ending on the fiscal year end of the merged entity shall also be filed with the department in accordance with Section 109 of this manual.

Section 105. MINIMUM OCCUPANCY FACTOR

To assure that only program costs are compensated under this payment system and to encourage maximum occupancy, a minimum occupancy level shall be applied to Medicaid inpatient capital costs attributed to the program based on licensed beds available during the prior year.

(a) Hospitals with 100 or less licensed beds shall have a minimum occupancy factor of sixty (60) percent applied.

(b) Hospitals with 101 or more licensed beds shall have an occupancy factor of seventy-five (75) percent applied.

(c) Newly constructed hospitals shall be allowed one (1) full rate year before the minimum occupancy factor shall be applied.

Section 106. UNALLOWABLE COSTS

(a) The following costs shall not be considered allowable costs for Medicaid reimbursement:

(1) Costs associated with political contributions.

(2) The cost associated with legal fees for unsuccessful lawsuits against the cabinet. Legal fees relating to lawsuits against the cabinet shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and

(3) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities. However, costs (excluding transportation costs) for training or education purposes outside the Commonwealth of Kentucky shall be allowable costs. If these meetings are not educational, the cost (excluding transportation) shall be allowable if educational or training components are included.

(b) Since the costs in the referenced Section are currently not identified by the Medicare or Medicaid cost report, hospitals shall identify these unallowable costs on the Supplemental Medicaid Schedule KMAP-1. The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report. The purpose of the Supplemental Medicaid Schedule KMAP-1 is to identify these unallowable costs for exclusion from the prospective rate computation.

Section 107. TRANSPLANTS

The program shall reimburse hospitals for transplants at the lessor of 80% of covered charges or a flat fee not to exceed $75,000. An exception to this limit may be made by the Commissioner, Department for Medicaid Services, on a case-by-case basis when the maximum payment limit restricts or prohibits the availability of the needed transplant procedure or service.

The costs associated with transplants shall not be included in allowable Medicaid costs. The charges and costs shall be reported in the total hospital charges and total hospital costs but shall not be included in the Medicaid charges or payments.

Section 108. RETROACTIVE SETTLEMENTS

Revision of the prospective payment rate shall be made under the following circumstances:

(a) If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data shall not constitute a computational error.

(b) If a determination of misrepresentation on the part of the facility is made by the program.

(c) If unaudited data is utilized to establish the universal rate, the rate shall be revised when the audited cost report is received from the fiscal intermediary or an independent audit firm under contract with the Department for Medicaid Services. If circumstances (a) or (b) occur, a settlement or revision shall be made only after the audited cost report is received from the fiscal intermediary. Factors which may affect the cost basis are costs utilized in determining Medicaid capital costs, i.e., total inpatient cost and total capital cost, and Medicaid allowable costs.

In accordance with Medicaid regulations at 42 CFR 447.271, Medicaid payments for inpatient hospital services shall be adjusted for the lesser of

total prospective payments or customary charges at the end of the prospective rate year. There shall be no allowance made under the prospective system for the carry forward provision utilized by Medicare (Title XVIII) in regard to the lesser of prospective payments or customary charges for inpatient services.

Section 109. COST REPORTING REQUIREMENTS

Each hospital participating in the Kentucky Medicaid Program shall submit an annual cost report, (HCFA 2552) including the Supplemental Medicaid Schedules, in the manner prescribed by the Medicaid Program. The cost report shall be submitted within five (5) months after the close of the fiscal year. An extension shall not be granted by the Medicaid Program. If the filing date lapses, the Program shall then suspend all payments to the facility until an acceptable cost report is received. The reports shall be filed for the fiscal year used by the facility.

Section 110. ACCESS TO SUBCONTRACTOR'S RECORDS

If the hospital has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a twelve (12) month period, the contract shall contain a clause giving the department access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor.

Section 111. AUDIT FUNCTION

After the hospital has submitted the annual cost report, the program shall perform a limited desk review. The purpose of a desk review is to verify prior year cost to be used in setting the prospective rate. The Medicare intermediary shall be informed of any findings as a result of this desk review. Under a common audit agreement, the Medicare intermediary provides Medicaid with copies of any audits performed by Medicare (Title XVIII) and Medicaid (Title XIX) purposes. However, the program may choose to audit even though Medicare does not.

Section 112. DUAL LICENSED AND SWING BEDS

(a) DUAL LICENSED BEDS

Effective January 1, 1997, the department shall no longer reimbursedual licensed beds in hospitals.

(b) SWING BEDS

Federally defined swing beds shall be reimbursed by the program at the weighted average payment rate for routine services for the prior calendar year for all nursing facilities (excluding intermediate care facilities for the mentally retarded and developmentally disabled) in the state, depending on the level of care requirements of the patient in the swing bed.

(c) ANCILLARY SERVICES FOR DUAL LICENSED AND SWING BEDS

Payments for reimbursable ancillary services provided to nursing patients in dual licensed or swing beds shall be based on a facility-specific cost-to-charge ratio with a settlement to actual cost at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular nursing care setting.

At the end of each facility's fiscal year a KMAP-2 and a KMAP-3

shall be filed with the cost report. The Medicaid Program shall make a final settlement on the ancillary services provided to patients in dual licensed beds. A separate KMAP-2 and KMAP-3 should be completed for each level of care. For swing bed, the usual Medicare cost report forms shall be completed.

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Section 113. REIMBURSEMENT REVIEW APPEAL PROCESS

Participating hospitals are provided a mechanism for a review of program decisions when any of the following circumstances occur:

(a) The addition of new and necessary services requiring Certificate of Need approval.

(b) Major changes in case mix.

(c) Major changes in types or intensity of services.

(d) Cost of improvements incurred because of certification or licensing requirements established after payment rates were established if those costs were not considered in the rate calculation.

(e) Extraordinary circumstances which may include fires, floods, etc.

(f) Program decisions of a substantive nature relating to the application of this payment system.

The request for a review will follow the review and appeals process.

Section 114. PSYCHIATRIC HOSPITALS SUPPLEMENTS

Psychiatric hospitals shall be reimbursed in accordance with this reimbursement manual for hospital inpatient services, except as specified in this supplemental section.

(a) MAXIMUM PAYMENT

The upper limit shall be established at the weighted median of the array of allowable costs for all participating psychiatric hospitals, except that disproportionate share hospitals, as defined in this Section, shall have a payment rate calculated in accordance with Section 102A.

(b) DISPROPORTIONATE SHARE HOSPITALS

Psychiatric hospitals which qualify as disproportionate share hospitals are classified, as appropriate, as the various types shown in Section 102C of this manual.

(c) MEDICAID UTILIZATION

Hospitals having a Medicaid utilization of thirty-five (35) percent or

higher shall have an upper limit established at one-hundred and fifteen (115) percent of the weighted median.

(d) OCCUPANCY FACTOR

A minimum occupancy level will be imposed relative to Medicaid inpatient capital cost as outlined in Section 105.

(e) DEPRECIATION

Medicaid inpatient capital costs will be based on Medicare cost finding principles including full allowance for depreciation cost.

(f) CONTRACTUAL INPATIENT SERVICES

A psychiatric hospital designated by the cabinet as a primary referral and services resource for children in the custody of the Cabinet for Families and Children shall be exempt from the upper limit for the array and shall be paid at the actual projected cost with no year end settlement to actual cost; the projected cost may be adjusted for usual DRI cost of living increases.

Section 115. HOSPITAL INDIGENT CARE REPORTING REQUIREMENTS

All hospitals shall report monthly data on a quarterly basis the care provided to indigent individuals and families as defined in state law, including care provided to indigent persons age twenty-two (22) to sixty-four (64) in a psychiatric hospital, excluding nonemergency care provided through a hospital emergency room.

Section 116. DEFINITIONS

The following terms are used throughout the manual and are defined in the following context.

(a) Allowable inpatient operating cost per diem – the allowable inpatient operating cost computed as a per diem amount after exclusion of unallowable operating costs and applications of upper limits.

(b) Base rate – The sum of the allowable inpatient operating cost per diem, the allowable capital cost per diem, and the allowable professional component cost per diem.

(c) Base year – The base year is the facility's fiscal year used for setting a rate. Under this system, payment to hospitals is determined prospectively by establishing a base year cost for the hospital. The base year cost for the hospital is the latest available Medicaid cost report data trended to the beginning of the universal rate year using the Data Resources, Inc. trend factor.

(d) Cost basis – Cost basis refers to the total allowable Medicaid inpatient costs incurred by the provider in the base year.

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(e) Universal rate year – The universal rate year, under the prospective payment system is the year beginning January 1 for which payment rates are established for all hospitals for a calendar year regardless of the hospital's fiscal year end.

(f) University teaching hospital – A hospital is designated to be a university teaching hospital is owned or operated by a university with a medical school.

(g) Low income utilization rate – For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

(1) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of the cash subsidies) in the same cost reporting period; and

(2) The total amount of the hospital's charges for inpatient services attributable to charity care (care provided for individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies for patient

services received directly from the State and local governments in the period attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid) that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross, etc.

Section 117. SUPPLEMENTAL MEDICAID SCHEDULES AND INSTRUCTIONS

This section contains the supplemental Medicaid schedules and instructions used for hospital rate setting purposes.

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INSTRUCTIONS FOR SUPPLEMENTAL MEDICAID SCHEDULE

KMAP-1

NOTE: FOR HCFA-2552-92 (11-92)

ine 1 – Enter amount paid as legal fees associated with lawsuits brought against the Cabinet for Human Resources. (See " Medicaid Reimbursement Manual for Hospital Inpatient Services", Section 106(a)(2).

ine 2 – Enter all expenses associated with political contributions.

ine 3 – Enter all expenses associated with travel outside the Commonwealth.

ine 4 – Sum of lines 1, 2, and 3.

olumn 3 Enter amounts from HCFA-2552-92, Worksheet B, Part I, Column 25 on the appropriate lines, as indicated. Note that Line 11A and 11B are taken from Worksheet D-2 as indicated, and the total of these two should equal the amount of Worksheet B, Part I, Line 70.

Line 13 – Enter sum of lines 5 through 12.

Line 14 – Enter amount from line 4.

Line 15 – Divide the non-allowable cost on line 14 by the total cost on line 13 and enter answer.

olumn 4 Lines 5 through 12. Multiply the ratio from line 15 by each amount entered on lines 5 through 12 and enter answers on the appropriate line of column 4.

Line 13 – Enter sum of line 5 through 12. Sum in column 4, line 13 should equal the non-allowable cost on Line 4.

Line 16 – Enter only the sum of Lines 5A, 6, and 10A. Line 5B should only be included if the cost is applicable to a psychiatric or rehabilitation unit.

Line 17 – Divide the Medicaid Inpatient Allowable Cost (HCFA-2552-92, 11/92, Worksheet E-3, Part III, Total of Lines 1 through 5 plus 5A) by the Total Inpatient Allowable Cost (HCFA-2552-92), Worksheet B, Part I, Column 25. Total expenses less amounts on Line 60 through to total expenses with exception of Line 70 which should be included in Total Inpatient Allowable Cost.

Line 18 – Multiply the amount entered on Line 16 by the ratio on Line 17 to determine the Medicaid portion of the non-allowable cost.

Line 19 – Deduct the amount entered on Line 18 from the Medicaid Inpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Line 6).

Line 20 – Enter only the sum of the amount of non-allowable cost from Lines 7 and 10B.

Line 21 – Divide Medicaid Outpatient Allowable Cost (HCFA-2552-92, Worksheet E-3, Part III, Column 2, Line 6) by the Total Outpatient Allowable Cost (HCFA-2552-92) Worksheet B, Part I, Column 25, Lines 60 through 63.

Line 22 – Multiply the ratio from Line 21 by the amount from Line 20.

Line 23 – Deduct the amount on Line 22 from the amount entered on Worksheet E-3, Part III, Column 2, Line 6.

SUPPLEMENTAL MEDICAID SCHEDULE I

Computation of Legal Fees, Political Contributions, and Out-of-State travel not Allowable to Medicaid Services

Legal Fees _____
Political Contributions _____
Out-of-State Travel _____
Total Non-Allowable Cost _____

HOSPITAL _____
VENDOR NO _____
PERIOD FROM _____
PERIOD TO _____

Column 1	Column 2	Column 3	Column 4
COST CENTERS	From Medicare Cost report Worksheet B	Accumulated Cost	Allocated Non-Allowable Costs
Inpatient routine Service A. Hospital	Total of Lns. 25-30 & 33		
B. Sub Providers (other than Inpatient Hospital)	Lns. 31,32, 34-36		
Ancillary Service Cost Center	Total of Lines 37-59		
Outpatient Service Cost Centers	Tot Lns. 60-63		
Home Program Dialysis	Ln. 64		
Ambulance Services	Ln. 65		
A. Intern-Res. Srvc. Not Appr. (I/P) D-2, Ln. 19, Col. 2*	Ln. 70		
B. Intern-Res. Srvc. Not Appr. (O/P) D-2, Line 23, Col. 2*			
[illegible] Cost Centers	Ln. 71-94		
[illegible]-Reimbursable Cost Centers	Tot. Lns. 96-103		
Total Expenses (Sum of Lns. 5-12)			
Total Non-Allowable Costs (Line 4)			
Unit Cost Multiplier (Ln. 14 / Ln. 13)			
Non-Allowable Cost Applicable to Inpt. Costs			
Medicaid Inpatient Allowable Cost (Supplemental Worksheet E-3, Part III. Total of Lns. 1 thru 6 plus 7b, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached			
Medicaid Non-Allowable Cost Line 16 X Line 17			
Medicaid Allowable Cost. Deduct the amount entered on Line 18 from the Medicaid Services Inpatient Cost on E-3 Part III, Col 1, Line 6			
OUTPATIENT			
Non-Allowable cost applicable to outpatient cost from line 7 and 10B.			
Determination of Medicaid Non-allowable Cost. (See Instructions Attached)			
Medicaid Non-Allowable Outpatient Cost. (Line 20 X Line 21)			
Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 22 from the Medicaid Services Outpatient Cost on E-3 Part III Col 2 Line 6			

Costs are broken between Inpatient and Outpatient Departments on W/sheet D-2

Attachment 4.19-A
Exhibit A

State Kentucky

Page 117.04

COMPUTATION OF DUAL LICENSED ANCILLARY COST

HOSPITAL VENDOR NUMBER _____

ICF DUAL LICENSED PROVIDER NUMBER _____
SNF DUAL LICENSED PROVIDER NUMBER

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41 RADIOLOGY-DIAGNOSTIC												
42 RADIOLOGY-THERAPEUTIC												
43 RADIOISOTOPE												
44 LABORATORY												
45 PBP CLINIC LAB SVC-PRG. ONLY												
46 WHOLE BL. & PK. RED BL. CELLS												
48 IV THERAPY												
49 RESPIRATORY THERAPY												
51 OCCUPATIONAL THERAPY												
53 ELECTROCARDIOLOGY												
54 ELECTROENCEPHALOGRAPHY												
55 MED. SUPPLIES CHG. TO PT.												
56 * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING) _____

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104) _____

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-92, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MULTIPLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND CHARGES PRIOR TO OCTOBER 1, 1990 ONLY

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MAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

HOSPITAL _____

VENDOR # _____

PERIOD FROM _____ PERIOD TO _____

1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 - Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13.

* Effective for services provided after October 1, 1990

SUPPLEMENTAL MEDICAID SCHEDULE 4

FACILITY: FYE:

VENDOR NUMBER:

a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2-OB'S OR PHYSICIANS WHO OFFERED NON-EMERGENCY OBSTETRIC SERVICES.) Yes ____ No ____

b. Does your facility predominantly serve individuals under 18 years of age? Yes ____ No ____

If yes, indicate the percent of the individuals under 18 years of age. % ____

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Yes ____ No ____

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments. $ ____

3 Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments. $ ____

4. Enter the total amount of the facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services. $ ____

5 Enter the total amount of the facility's charges for inpatient services. $ ____

The above statements are accurate and correct to the best of my knowledge.

Signed: ____
President, Administrator, or Chief Financial Officer

SUPPLEMENTAL WORKSHEET 5

(MEDICAID SERVICES DEPRECIATION)

HOSPITAL _____
VENDOR # _____
PERIOD FROM _____ PERIOD TO _____
REASON FOR REVISION _____

A. INSTRUCTIONS

B. CAPITAL COST COMPUTATION

1A. TOTAL CAPITAL COST (W/S B, PART II + B PART III COLUMN 4A – LINE 95) LESS NON-ALLOWABLE COST CENTERS) LESS INTEREST/INSURANCE/TAXES (RELATED TO CAPITAL COST W/S A-7 PART III) = ADJUSTED TOTAL CAPITAL COST.

LINE 1B. | | | |

2A. ADJUSTED TOTAL CAPITAL COST (LINE1) / TOTAL CAPITAL COST = RATIO.

LINE 2B. | | | |

3A. RATIO (LINE 2) X MEDICAID SERVICES CAPITAL COST (ROUTINE AND ANCILLARY W/S D, PARTS I AND II = ADJUSTED MEDICAID SERVICES CAPITAL COST (MEDICAID SERVICES CAPITAL COST LESS INT./INS./TAXES).

LINE 3B. | | | |

4A. TOTAL BLDG. AND FIXTURES / TOTAL CAPITAL COST = RATIO
(W/S B, PART II & B PART III COL. 1 & 3 LINE 95) LESS NON-ALLOWABLE COST CENTERS)
(W/S B PART II & B PART III 4A. LINE 95 LESS NON-ALLOWABLECOST CENTERS)
(RATIO OF BLDG. AND FIXTURES TO TOTAL CAPITAL COST).

LINE 4B. | | | |

5A. RATIO (LINE 4) X MEDICAID SERVICES ADJUSTED CAPITAL COST (LINE 3) = MEDICAID SERVICES BLDG. AND FIXTURES .

LINE 5B. | | | |

6A. MEDICAID SERVICES CAPITAL COST LESS MEDICAID SERVICES BLDG.& FIXTURES (LINE 5) = MEDICAID SERVICES MOVABLE EQUIP. AND INTEREST/ INSURANCE / TAXES.

LINE 6B. | | | |

7A. 65% X MEDICAID SERVICES BLDG .& FIX. (LINE 5) = ALLOWABLE MEDICAID SERVICES BLDG. & FIXTURES

LINE 7B. | 0.65 | | |

8A. MEDICAID SERVICES EQUIPMENT AND INTEREST/INSURANCE/TAXES (LINE 6) + MEDICAID SERVICES ALLOWABLE BLDG. & FIXTURES (LINE 7) = MEDICAID ALLOWABLE INPATIENT CAPITAL COST

Line 8B. | | | |

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SUPPLEMENTAL MEDICAID SCHEDULE 6

PROFESSIONAL COMPONENT/LABOR-DELIVERY ROOM DAYS/NURSERY INFORMATION

HOSPITAL _____
VENDOR NUMBER _____
PERIOD FROM _____
PERIOD TO _____

AUDITOR _____
DATE _____
REVIEWER _____
DATE _____

I. HOSPITAL-BASED PROFESSIONAL COMPONENT SERVICES

COST CENTERS	Col. 1 TOTAL PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 2 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG. INPATIENT	Col. 3 TOTAL PROFESSIONAL COMPONENT CHG. OUTPATIENT	COL. 4 TOTAL MEDICAID SERVICES PROFESSIONAL COMPONENT CHG OUTPATIENT
ANESTHESIOLOGY				
RADIOLOGY-DIAGNOSTIC				
RADIOLOGY-THERAPEUTIC				
RADIOSOTOPE				
LABORATORY				
EKG				
EEG				
BLANK				
BLANK				
EMERGENCY ROOM				

WHEN PROFESSIONAL COMPONENT SERVICES ARE INCLUDED IN THE COST REPORT, A SUPPLEMENTAL WORKSHEET D-3 SHOULD BE COMPLETED. ALSO, THIS OFFICE MUST RECEIVE THIS SUPPLEMENTAL SCHEDULE IDENTIFYING, BY COST CENTERS, THE TOTAL PROFESSIONAL COMPONENT CHARGES AND THE MEDICAID SERVICES PROFESSIONAL COMPONENT CHARGES.

II. LABOR/DELIVERY ROOM DAYS

DOES TOTAL HOSPITAL ADULT AND PEDIATRIC DAYS (EXCLUDING SWING BEDS) ON WORKSHEET S-3 (HOSPITAL STATISTICAL DATA) LINE 1.01, COLUMN 6 INCLUDE LABOR/DELIVERY ROOM days.

YES _____ NO _____

IF NO, PLEASE INDICATE TOTAL LABOR/DELIVERY ROOM DAYS. _____

III. NURSERY DAYS

PLEASE INDICATE THE FOLLOWING:

1. THE NUMBER OF MEDICAID NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

2. THE NUMBER OF MEDICAID NURSERY DAYS ON WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

3. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE PAID AT AN AMOUNT GREATER THAN ZERO. _____

4. THE NUMBER OF MEDICAID NEONATAL NURSERY DAYS FROM WORKSHEET S-3, COLUMN 5 THAT ARE ZERO PAID. _____

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SUPPLEMENTAL MEDICAID SCHEDULE 8

COMPUTATION OF EXCLUDED ALLOWABLE

PROFESSIONAL COST WHICH IS NOT REIMBURSABLE

BY MEDICAID SERVICES ON WORKSHEET D-3

AC. _____

ENDOR #: _____ PERIOD FROM _____ PERIOD TO _____

OL. 1 Cost Centers	COL. 2 Cost From Wk/S A-8 or A-8-2
. CRNA	
. Physical Therapist	
. Respiratory Therapist	
. Clinic	
. Other	
. Total	

. Determine a ratio of Hospital Inpatient Cost to total Hospital Cost _____

. Determine a ratio of Hospital Outpatient Cost to total Hospital Cost _____

. Multiply the ratio from Line 7 & Line 8 by the total amount entered on line 6 to determine the cost applicable to Inpatient and Outpatient services.

a. Inpatient Cost (Excluded Allowable Professional Cost) _____

b. Outpatient Cost (Excluded Allowable Professional Cost) _____

0. . nine the ratio of Medicaid Services Inpatient Cost to total Inpatient Cost _____

1. Determine the ratio of Medicaid Services Outpatient Cost to total Outpatient Cost _____

2. Multiply the ratio of Medicaid Services Inpatient Cost Line 10 by the amount entered on line 9a for Medicaid Services Inpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col. 1. _____

3. Multiply the ratio of Medicaid Services Outpatient Cost Line 11 by the amount entered on line 9b for Medicaid Services Outpatient Cost. Enter the amount on Wkst. E-3 Part III, Line 5a, Col.2. _____

INSTRUCTIONS

LINE #

7. Divide the sum of Worksheet B, Part I, col. 25, lines 25 through 33, lines 37 through 59, and line 70 by the sum of Worksheet B, Part I, col. 25, line 103.

8. Divide the sum of Worksheet B, Part I, col. 25, lines 60 through 63 by the sum of Worksheet B, Part I, col. 25, line 103.

10. Divide the amount of Medicaid Services Inpatient cost (HCFA 2552-92,11/92, E-3, Part III, Col. 1 Total of lines 1 through 5) by the Total Hospital Inpatient Cost (Sum of Worksheet B, Part I, col. 25 lines 25 through 33, lines 37 through 59, and line 70).

11. Divide the amount of Medicaid Services Outpatient cost (HCFA 2552-9292, 11/92, E-3 Part III, Col. 2 Total of lines 1 through 5 PLUS LAB COST (D PART V) by the Total Hospital Outpatient Cost (Sum of Worksheet B, Part I col. 25, lines 60 through 63).